

# Commonwealth Of Kentucky

## Health Insurance Application

(for Use By Employers NOT in the State Payroll System - UPPS)

### Reason for Application

☐ < New Employee ☐ < New Group ☐ < COBRA ☐ < Other  
☐ < Open Enrollment ☐ < Move Out of Service Area\* ☐ < Previously Waived\*\*

\* If Moving Out of the Service Area, enter the Qualifying Event Date: \_\_\_\_\_

\*\* If you Previously Waived, enter the Qualifying Event Date AND a description of the Qualifying Event: \_\_\_\_\_ Date \_\_\_\_\_ Description \_\_\_\_\_

### MUST BE COMPLETED BY THE INSURANCE COORDINATOR

|  |  |                      |  |
|--|--|----------------------|--|
| Insurance Effective Date   |  | Company Number       |  |
| <input type="text"/> / <input type="text"/> / <input type="text"/> |  | <input type="text"/> |  |
| Home County  | Work County  | Contiguous County    |  |
| <input type="text"/>   | <input type="text"/>   | <input type="text"/> |  |
| Dual Employee Code   | Deduction Start Date (BOEs ONLY)                                   |                      |  |
| <input type="text"/>   | <input type="text"/> / <input type="text"/> / <input type="text"/> |                      |  |

### SECTION I: DEMOGRAPHIC INFORMATION

### PLEASE PRINT

SSN    -   -

Date of Birth  /  /   
Month Day Year

Name (First, MI, Last)

Gender Marital Status

☐ < Male ☐ < Married  
☐ < Female ☐ < Single

Street Address

PO Box / Apt. #

City, State, Zip Code

County of Residence

Country/Mail Code -- If NOT U.S.A.

Hire Date

Employer Name

Policyholder's Daytime Phone Number

### SECTION II: PLAN SELECTION

|   |   |  |  |                          |  |   |
|---|---|--|--|--------------------------|--|---|
| <b>1. County of Coverage</b><br><small>Check only one</small><br><input type="checkbox"/> < Home<br><input type="checkbox"/> < Work<br><input type="checkbox"/> < Contiguous<br>Name of County of Coverage: _____ | <b>2. Plan Code</b><br><input type="text"/><br><i>If waiving coverage, enter 999 and go to Section VI</i> | <b>3. Option</b><br><input type="checkbox"/> < A<br><input type="checkbox"/> < B | <b>4. Level of Coverage</b><br><input type="checkbox"/> < Single<br><input type="checkbox"/> < Parent Plus<br><input type="checkbox"/> < Couple<br><input type="checkbox"/> < Family | <b>5. Not Applicable</b> | <b>6. Cross-Reference</b><br>***<br><input type="checkbox"/> < Yes<br><small>See below table in Section IV</small> | <b>7. PCP Selection</b><br>PCP# -- If required by Carrier<br>Yes No<br>Are you a current patient? <input type="checkbox"/> <input type="checkbox"/> |
|---|---|--|--|--------------------------|--|---|

### SECTION III: PRIOR HEALTH COVERAGE

Have you, or any eligible dependent, been covered by a health insurance plan during the twelve months prior to this coverage going into effect? Yes No ☐ ☐

If yes, provide the following information. This information will be used to determine waiting periods for pre-existing conditions.

Type of Coverage: ☐ < Group ☐ < Individual ☐ < COBRA ☐ < Medicare ☐ < Medicaid

Level of Coverage: ☐ < Single ☐ < Parent Plus ☐ < Couple ☐ < Family

Insurance Company Name

Name of Employer Providing Coverage (If group policy)

Effective Date

Termination Date

### SECTION IV: SPOUSE AND/OR DEPENDENT INFORMATION

| Social Security Number | Name<br>(First, MI, Last) | Gender<br><i>Circle One</i> | Date Of Birth<br>(MM/DD/YYYY) | Rel.<br>Code | PCP #<br>(If required) | Current<br>Patient?<br><i>Circle One</i> |
|------------------------|---------------------------|-----------------------------|-------------------------------|--------------|------------------------|--|
|                        |                           | M F                         |                               |              |                        | Y N                                      |
|                        |                           | M F                         |                               |              |                        | Y N                                      |
|                        |                           | M F                         |                               |              |                        | Y N                                      |
|                        |                           | M F                         |                               |              |                        | Y N                                      |
|                        |                           | M F                         |                               |              |                        | Y N                                      |

\*\*\*TO BE COMPLETED BY THE SPOUSE'S INSURANCE COORDINATOR (Only needed if this is a Cross-Reference application):

Spouse's Company  
Number (REQUIRED) -->

Spouse's Dual Employee  
Indicator, if applicable -->